

Every known method was used in a futile attempt to revive the patient, but after 18 hours of artificial respiration, the heart had stopped beating. In spite of the fact that drug poisoning seemed to have caused the death, a careful inquiry revealed some important facts. Her sister said that the patient had suffered from headaches frequently even as a child, without there being any apparent cause. An autopsy was obtained, and a large chronic internal hydrocephalus was found, due, in all probability, to a meningeal affection in childhood having occluded the foramen of Magendie. A careful examination at the onset of the patient's symptoms should have revealed signs of intercranial pressure.

Doctor Shiels, closing: I agree with Doctor Power with regard to the efficiency of strong aromatic spirits of ammonia in the relief of headache. I look upon it as a surprise stimulant. As far as a working classification is concerned, that is a matter for the individual to decide and we always find patients grateful for the cure of headache whether this be done by a physician or a next door neighbor. When I give a purge I do not hold out a definite promise that I shall cure their headaches. I try to remove any reflex cause without explanation, for headaches are, as a rule, composite in character and hard to cure. Doctor Bine makes a strong point in the necessity for careful history taking and his interesting case proves this without a doubt. The use of the ophthalmoscope is all important in the diagnosis. The popular use of coal tar preparations is much to be deplored. We should treat headache people with caution.

## A REPORT OF SEVERAL CASES OF NEPHRITIS WITH UNUSUAL FEATURES.\*

By CHARLES R. HARRY, M. D., Stockton.

These cases are interesting from the fact that, although the patients were all comatose before they died, none of them had any muscular twitching or convulsions. There are also some other unusual features connected with the cases.

Case 1.—Male. Age 36. Came to my office October 10th. Complained of more or less gastric distress after eating, some shortness of breath on exertion, gradual failure of sight and weakness. Very nervous. Had lost 44 pounds in last three or four months. Present weight, 186 pounds. Physical examination—Slightly jaundiced; arteries atheromatous. Pulse 100, regular in rhythm but not strong. Temperature normal, systolic murmur at pulmonary site, also over aorta. Urine normal in quantity, but contained albumen and casts. Patient was put on a diet of easily digested liquid and soft solid food. A mixture of bismuth, also strychnia and digitalis and one-minim doses of 1% nitro-glycerin were given internally. Patient improved until November 21st. I was called to his home. Found that he had eaten some very indigestible food. He was troubled with a great deal of gas in the stomach, was very short of breath and excessively nervous. Quantity of urine still normal. Patient was put to bed and only liquid food allowed.

Strychnia, digitalis and nitro-glycerin were prescribed. Under this treatment the gastric symptoms and shortness of breath subsided. The urine, however, gradually decreased in quantity until he passed only about a pint in twenty-four hours. The nervousness increased and he became hysterical at times, crying and declaring he was never going to get well. The urine became greatly diminished in quantity, averaging from 7 to 14 ounces in twenty-four hours, in spite of the use of diuretics, large quantities of water and sweats. He soon became delirious and remained in this condition four days.

At times the nurses were unable to keep him in bed. There was no twitching or convulsions. About forty-eight hours before he died he became comatose and remained so until his death, December 10th.

Case 2.—Male. Age 44. Came under my care June 14, 1908. Complained of weakness, shortness of breath on exertion, very rapid heart action and indigestion. Very nervous man and indiscreet in his diet. Lost considerable in weight during last three months.

Pulse 132-136, high tension. Systolic murmur at mitral valve; apex beat one inch to left of mammary line. Urine contained albumen and casts, quantity about normal. Patient was put on a strict diet. Bromides given to quiet the rapid heart action and relieve nervousness and iron for the anemia. Large quantities of water were also advised, together with laxatives. Patient improved for a time; pulse came down to 96-108, shortness of breath not bad so long as he would keep quiet. Still felt very weak, but would not go to bed and at times would not adhere to the diet prescribed. About November 11th was taken with a severe attack of indigestion, due to indiscretion in diet.

Heart and kidneys both became worse after this. Was unable to sleep without hypnotics. Urine became very scanty and was loaded with albumen. November 24th was slightly delirious, but there was no twitching. The delirium gradually increased until he became very violent. This continued until November 26th, when coma developed, and he remained in this condition until he died, November 27th.

Case 3.—Female. Age 43. Was confined at full term December 27th. Labor was very tedious and a high forceps delivery was performed. During pregnancy no albumen was found in the urine and the quantity was always about normal.

Convalescence was uninterrupted until January 1st, when she had a little rise of temperature. The quantity of urine, however, was normal and no albumen was present. Uterus was washed out and her temperature came down to normal. As the patient lived twelve miles out in the country, I did not see her every day. January 3d I was sent for, as the nurse stated she had not passed urine since 11 a. m., January 2d. I arrived at 2 p. m., used a catheter, and to my surprise only drew off one dram of urine. This represented the secretion for twenty-seven hours. She felt quite comfortable, however, excepting a little nervous.

There was no headache, twitching or other uremic symptoms. She was immediately brought to St. Joseph's Hospital, and, in spite of profuse sweats, large quantities of water and diuretics, the urine did not increase much. She was catheterized every six hours, as she could not pass water naturally, and only from one to three drams removed at a time. The quantity of urine secreted would only average from  $\frac{1}{2}$  to 1 ounce for each twenty-four hours. It was loaded with albumen. Patient felt rather nervous and had an ulceration of the gums, but no twitching at all.

In the evening, became slightly delirious and a complete hemiplegia of the left side developed. She became comatose soon after this and died the following forenoon.

This case is remarkable from the fact that she lived six days with a total secretion during that time of only four to six ounces of urine. She was perfectly conscious until the night before she died and did not complain of anything except the soreness of her gums from the ulceration.

Case 4.—Male. Age 52. Commenced treatment about November 15th. Troubled with shortness of breath and sleepiness. If he sat down in a chair, even in the daytime, he would go to sleep in a few minutes. Puffiness under the eyes; very fat, weight

\*Read before the San Joaquin Valley Medical Association, 1909.

260 pounds. Pulse rapid and not very strong, heart tones clear; edema of legs. Urine scanty, but no albumen could be found after several examinations. No examination was made for casts.

I put him on digitaline gr. 1/5 and strychnia gr. 1/30 ever six hours. Also diuretic grs. xv every four hours and a strict diet. His urine increased in a short time to over three quarts in twenty-four hours. Shortness of breath gradually lessened and the sleepy feeling was much less. Weight decreased gradually. Lost over 30 pounds in two months' time and felt much stronger than when he commenced treatment.

On the afternoon of January 23d was taken with a severe attack of appendicitis. I was not called until about noon January 24th. After examining him an operation was recommended if he was not better in a short time. I saw him again at 5 p. m. and he was much worse, so advised an immediate operation. Pulse at this time was 130, temp. 103.5°. Urine was not examined. He was removed at once to St. Joseph's Home and prepared for the operation, which was performed early in the evening. The appendix was gangrenous; it had already perforated and a large abscess had formed. The abscess cavity was swabbed out and pieces of the gangrenous appendix were removed with forceps. The cavity was packed with gauze and the patient removed to his bed.

Pulse 148 after the operation. Monday noon his pulse was 94, temp. 101.8°. A pint of normal salt solution was administered per rectum every four hours. The quantity of urine kept up until late Monday afternoon, when it became scanty and contained a great deal of albumen. Temp. 104.2°, pulse 116. From 11 p. m. Monday until 7 a. m. Tuesday (56 hours) he secreted 14½ ounces of urine, although diaphoretics, diuretics and large quantities of water were given. During the time there was no twitching or convulsions.

Patient became delirious Wednesday night and died in coma the next morning.

### VISIBLE MOVEMENT OF BLOOD IN RETINAL VESSELS.

By C. S. G. NAGEL, M. D., San Francisco, Instructor in Ophthalmology University of California.

Movement of the blood in retinal vessels had been observed in the early days of ophthalmoscopy in a few instances by Ed. Jaeger, Liebreich and von Graefe in local changes, i. e., detachment of retina and in a case of "neuritis"—also by V. Graefe several times in the asphyctic stage of cholera. Subsequently the phenomenon has repeatedly been reported in cases of so-called embolism of the central retinal artery, in a majority of which, according to our present knowledge, it has probably been due to a local endarteritis proliferans. In the *Deutsche Medicin. Wochenschr.* No. 45, 1908, Th. Rehberg gives the extensive history of a case of aortic aneurysm, observed at the University Medical Clinic of Königsberg, making the following statement regarding the eyes—"Vision somewhat lowered in right eye, F. V. normal in both. The retinal veins are relatively large compared to the arteries; the bloodstream, especially in the veins of the right eye, is markedly retarded and plainly visible, the blood column being divided into pieces of a varying size, i. e. from big granules to cylinders, which are separated by light interspaces."

From the literature at my disposal (there is also no reference in the literature given by Groenouw Zu-

sammenhang von Augen—U. Allgemein—Krankheiten in Graefe—Saemisch, 2nd ed.) and the fact that Leber (1) in his exhaustive study passing in review all experimental and clinical data extant does not mention any similar observation, I believe Rehberg's to be the first observation of the kind, and I feel justified therefore in reporting a similar, regarding the eyes though much worse, history which I have been able to follow (October-December, 1908) in my service at the University of California Hospital. Doctor Moffitt has demonstrated the patient from the medical side before the San Francisco County Medical Society. I will only give the data in so far as they would seem to be of special interest here.

J. H., ironmolder, age 29. No previous illness. November 1907, during work, sudden sensation of jumping of eyes out of head and dizziness. Gradually getting worse with pain in eyes and sensation of blood trying to rush through skull and attacks of roaring in ears. Sight gradually had been failing in both eyes, until July, 1908, permanent blindness set in in right—sight having been hazy for one day, it had gone out next morning entirely. Patient has been hoarse since March, 1908, suffered frequently from frontal headache, and at times the top of scalp seems numb. Sight has persisted in left eye, but has acted in general as in right. At present (October, 1908) it is very bad, hazy. Patient becomes blind in attempt to cross room. Spending his time in bed whilst in the hospital, patient sees best in sitting posture with head bent forward, sight getting dim and leaving entirely at times if he leans backwards or even lifts head merely, but returns promptly on lowering head again. The temporal, facial, carotid, subclavian and radial pulses are absent on both sides, the brachial and ulnar present on either side, but weak. The femoral pulses are present and those at the dorsum pedis, right and left are strong. Reflexes are normal, and so are sensations, though pinching of the skin anywhere seems to be very painful. Left side of skull very dull, especially over parieto-occipital region. Tenderness over left parietal eminence. Frequent clots of blood in right nostril since beginning of illness. Left vocal cord at first moving less than right, has become paralyzed during stay at hospital (examined by Doctor Albert B. McKee). Trigemini in sensory and motor portions intact, corneal reflexes prompt. Facial nerves intact. Blood pressure on legs October 7, maximum 220, minimum 160; October 12, 218; November 21, with Esmarch's on other leg, maximum 150, minimum 125, without Esmarch's 130 and 105. Patient had referred to occasional attacks of general convulsions with loss of consciousness and it was found that pressure on both carotids for about thirty seconds produces deep, noisy breathing with pallor of face and finally twitchings of face and arms, especially on right side. With twitching comes loss of consciousness, patient falls forward and respiration stops for a few seconds. Face then begins to flush and consciousness returns. On November 13, whilst rising in bed, patient had momentary loss of consciousness with slight, but regular, epileptic attack.